

Highland Hospital EEG Laboratory
Outpatient Scheduling: 585-341-0100
Inpatient Scheduling: 585-341-0074
Fax: 585-341-0202

PLEASE CALL THE HIGHLAND NEUROLOGY OFFICE AFTER FAXING THE REQUISITION AND DEMOGRAPHIC INFORMATION. *PLEASE DO NOT USE NAME STAMPS AS THEY DO NOT COME THROUGH ON THE FAX.*

Patient's Name: _____ Date of Test: _____

Age: _____ Address/Floor: _____

Type of EEG: ___ Routine ___ Portable
 ___ Sleep Deprivation Study ___ Brain Death

Is patient on O₂? ___ Yes ___ No Is patient on an IV? ___ Yes ___ No

Prior EEG? ___ Yes ___ No

When? _____ Where? _____

Diagnosis

Clinical Information (reason for EEG, seizure history, exam):

Medications: _____

Contra-indications to Hyperventilation: (circle one)

Poorly controlled HTN, increased ICP, severe COPD, or coronary artery disease.

Other Contra-indications: _____

Requesting Physician: (Please Print) _____

Phone Number/Pager: _____ Date: _____

Report(s) to: _____